Community health connection

September • 2012



Case File

Memorial Healthcare System • Broward County, Florida

System Takes a Broader Focus

Serving 800,000 people in South Florida between Miami and Palm Beach, Memorial Healthcare System strives to improve health, but they take a broader focus. With community and quality of life as key values, the system is continuously looking for the best ways to serve its communities.

MHS serves a densely populated urban area in and around Broward County, with more than 35 municipalities but only one large school district. The system includes five primary care clinics, six hospitals and other care facilities, as well as a provider service network that is an experimental service for Medicaid patients.

MHS is a tax-assisted hospital district, yet only 3% of its revenue is funded through taxes. Additionally, the system's primary care facilities treat those below 400% of the federal poverty guideline who are not eligible for Medicaid. Patients pay less than costs, on a sliding scale.

As one of the nation's first health systems to embrace Community Health Needs Assessments, MHS contracted with PRC to conduct their inaugural study in 1994. True to their key values, they customized their first survey to include quality of life issues as they sought data on other factors affecting their communities' health. In 1997, MHS joined forces with the Coordinating Council of Broward (CCB) to expand their impact.

According to MHS Director of Community Services Steve Sampier, one of the critical elements of the CCB is a Quality of Life Committee. This committee – which includes the major funders and service providers for the area's health, education, public safety and human services – determines the questions that will be included on each CHNA survey. Other area nonprofits that aren't CCB members are encouraged to make suggestions for the survey and participate on the Quality of Life Committee, though final decisions are made by the CCB Board. (To learn more about the Quality of Life Committee and to see past surveys, visit www.sfrpc.com.)

"We benchmark data from all of our

Inside...

partners and supplement those statistics with CHNA survey questions," explains Sampier. "Is the perception within the community the same as we see? With this data, we can find out."

The Quality of Life Committee uses this information to track the effectiveness of their work as well as the work of other agencies in the community, tweaking programs as needed.

"We count on PRC to make sure these questions are comparable to the state and the U.S. overall," says Sampier. "They're very flexible and have comparative data that we use to benchmark against. We then use the PRC data along with our own collected data to identify our priorities."

The action plans developed as a result of the 2011 CHNA were coordinated by a group within MHS. They contracted with the Broward Regional Health Planning Council – also a CCB member – to create an expanded task force that includes community agencies.

Mike De Lucca, President and CEO of the Broward Regional Health Planning Council and Chair of the CCB, says Broward County uses the CHNA as one of the key ingredients to create their overarching goals and health plan (see the Broward County HHS website at www.brhpc.org).

"We've been creating district health plans for more than 30 years," De Lucca says, "and the key drivers in the reports make it even more powerful."

Neighborhood Projects Built Communities

To further determine the issues within their communities and build relationships, MHS has taken its Health Intervention with Targeted Services (HITS) program door-to-door. For the past six years Neighborhood Project teams asked residents in nine different neighborhoods to name three things that needed to be improved in their neighborhoods and then took those responses and added it to the data gathered in their CHNAs.

None of the identified concerns were specifically about healthcare, though the results showed MHS that while they do provide good care in the communities, they still need to make an even bigger commitment to develop trust.

MHS now has more involvement and support within those communities, working within those areas to build community leadership, teaching leaders ways to strengthen their communities so that the system can further its role as a healthcare provider.

"We still connect with the people and leaders of those communities on a regular basis," says Sampier. "The PRC data that we have is absolutely invaluable in this project."

Learn more at www.bit.ly/MHScommhealth

The three-year district health plan priorities include:

Preventive care

Screenings such as mammograms and colonoscopies, especially for the uninsured, are key. Also, immunizations are a focus, especially for preschoolers.

Prenatal care

One surprise that the health assessment recently presented was the disparity within the Hispanic community for prenatal care. "That wasn't even on our radar," says Sampier. "It certainly wouldn't have become a priority without the data."

"We're currently mining our CHNA data further using PRCEasyView.com®. Then we'll be able to target geographic areas and demographic groups and focus our plan."

Access to care

Improving access to care is a continual goal, but the CHNA trends show that MHS is making headway. The system provides many opportunities within the community, including a team that goes door-to-door to let people know where they can find healthcare (see side bar). One way the team uses this data is by drilling down and targeting the zip codes and neighborhoods where residents have the most difficulty accessing healthcare. They have also extended clinic hours to better meet their communities' needs.

Affordability of health care

MHS is helping people learn more about their options when it comes to paying for their care through their door-to-door team, mobile health centers, eligibility assistance councilors and emergency room navigators.

Community health education

In an effort to improve healthcare access and affordability, MHS works to educate the community on various government programs, how to navigate these programs and the details regarding their private insurance.

Environmental issues

Understanding that health isn't just a healthcare issue, MHS also focuses on everything that interferes with good health and healthcare, including crime and poverty. These issues are primarily handled by partner agencies and referral services, though MHS is working with a CCB task force to try to establish a pilot project using common eligibility software that targets families with multiple needs, such as Medicaid, SNAP (food stamps) and more.

Sampier says the Community Health Needs Assessment data is also an integral part of their grant writing program. Using the data, MHS's three-person grant team within the Planning Department receives approximately 85% of the grants they apply for. The Children's Services Council, Health Foundation of South Florida, Broward County Human Services, the Blue Foundation and similar funders have provided financial support based on their CHNA data.

"We have received adolescent behavioral health grants, access grants – which we used for the door-to-door HITS team – navigation grants, disease management grants and more," says Sampier.

"Obviously, we care about the quality of life in its entirety here," Sampier explains, "which naturally affects the health of the community as well. At MHS, we just want to continue to make a real, positive impact throughout the community."

PRC welcomes our most recent CHNA clients

January-July 2012

Alexian Brothers Health System, Arlington Heights, IL
Aspen Valley Hospital, Aspen, CO
Barton Memorial Hospital, South Lake Tahoe, CA
Boys Town National Research Hospital, Omaha, NE
Central DuPage Hospital, Winfield, IL
Children's Hospital & Medical Center, Omaha, NE
Children's Mercy Hospitals and Clinics, Kansas City, MO
CHRISTUS St. Francis Cabrini Hospital, Alexandria, LA
Columbus Regional Hospital, Columbus, IN
Doctors Hospital, Columbus, GA
Edward Hospital & Health Services, Naperville, IL
Elmhurst Memorial Healthcare, Elmhurst, IL
Franciscan St. James Health, Chicago Heights, IL
Hamilton County Health Department, Noblesville, IN
Henry County Hospital, New Castle, IN
Hospital Consortium of San Mateo County, San Mateo, CA
Hughston Hospital, Columbus, GA
Ingalls Memorial Hospital, Harvey, IL
Little Company of Mary Hospital and Health Care Centers, Evergreen Park, IL
Memorial Hospital of Sweetwater County, Rock Springs, WY
Metropolitan Chicago Healthcare Council, Chicago, IL
Northern Arizona Healthcare, Flagstaff, AZ
Northwest Community Hospital, Arlington Heights, IL
Rapides Regional Medical Center, Alexandria, LA
Region 6 Behavioral Healthcare, Omaha, NE
Riverview Hospital, Noblesville, IN
Robert Wood Johnson University Hospital, New Brunswick, NJ
Saint Anthony Hospital, Chicago, IL
Santa Ynez Valley Cottage Hospital, Solvang, CA
Sarah Bush Lincoln Health Center, Mattoon, IL
St. Bernard Hospital and Health Care Center, Chicago, IL
St. Francis Hospital, Columbus, GA
St. Joseph Health System, Orange, CA
St. Peter's University Hospital, New Brunswick, NJ
Swedish Covenant Hospital, Chicago, IL
The Medical Center, Columbus, GA
University of Illinois Hospital & Health Sciences System, Chicago, IL
WNC Health Network, Asheville, NC

Did you know PRC clients also receive these services?

Prioritization of Health Needs:

- PRC facilitates an on-site meeting, which occurs concurrently with presentation of findings and can be appropriate for many group types, including hospital steering committee, advisory group, community leaders or board members
- Provides an unbiased and trained facilitator
- Utilizes Audience Response System technology for immediate feedback
- Includes time for hospital comment and participant discussion
- Creates buy-in, furthering the likelihood of sustainable success
- Offers a rationale for explaining the prioritization process on Form 990

Implementation Strategy Framework:

- Flexible and adaptable template for Implementation Strategy document
- Supplies an outline to incorporate hospital-specific details, CHNA description, identified health needs, the prioritization process and action plans
- Structure corresponds to PPACA requirements & Form 990 checklist

National Child & Adolescent Health Study

As children's health needs are often distinct from the needs of adults, this year PRC is conducting its first National Child & Adolescent Health Study. This study seeks to learn more about the health status, behaviors and needs of our nation's children as well as provide a benchmark for PRC clients conducting child-specific Community Health Needs Assessments.

This study will be conducted with 700 parents of children ages 0-17 and seeks to understand:

- Top health issues for children and adolescents
- Physical and mental health status
- Special health needs, including prevalence of selected medical conditions and managing these needs
- Prenatal and infant health
- Child & adolescent mortality
- Modifiable health risks, including nutrition, physical activity, tobacco utilization, substance abuse, injury and safety
- Behavioral concerns
- Access to healthcare services, insurance coverage, and utilization of local healthcare services
- Personal safety, including bullying, neighborhood crime, and helmet utilization
- Demographics – Gender, age/grade, race/ethnicity
- Resource awareness and utilization for healthcare information as well as parenting education programs.

Most Americans need to improve some aspect of their diet. Social factors thought to influence diet include:

- Knowledge and attitudes
- Social support
- Food and agricultural policies
- Economic price systems
- Skills
- Societal and cultural norms
- Food assistance programs

Conducting a Community Health Survey as Part of Your CHNA

Advantages

An understanding of the real barriers to healthcare access in your community.

Is it just cost and insurance, or is it not enough doctors, appointment availability, wait times, or inconvenient office hours? Lack of transportation? Cultural or language barriers?

A set of mental health status indicators.

How many of your population have been diagnosed with a depressive disorder? What about those who are symptomatic, but might not have been diagnosed or had any interaction with the mental healthcare system?

A population-level prevalence of routine medical and dental care for both adults and children.

How many have a regular source of care and have also received regular preventive care? And when?

An understanding of chronic disease in the community.

What is the current prevalence of diabetes? Are people even getting tested to determine if they are diabetic or prediabetic? Are your residents able to manage their chronic diseases effectively? Most chronic conditions are not reported to public health agencies and hospital data can only tell you about those ending up at your door. An upstream approach such as is available through primary data is needed to understand chronic diseases throughout the entire community.

Meaningful data about children's health.

Aside from birth-related statistics, secondary data are woefully lacking regarding children's health. Childhood obesity is an important issue, but do you know the proportion of children in your community that is overweight or obese? What are their physical activity habits, what are they eating each day, and how much time are they spending each day in front of computer and TV screens?

Disease prevalence measures.

Secondary data will tell you what diseases are leading to death, and while death rates for many of the leading causes are declining, their impact on quality of life, cost of medical care, and loss of productivity is arguably growing – diseases such as heart disease, stroke, cancers, diabetes, lung disease. Primary data can tell you how prevalent these are in your community; secondary data can't.

Indicators of injury and violence in your community.

Injury and violence are leading causes of death across the country, particularly for the non-elderly population. Are your residents "living safe"? What is their experience with violence, including domestic violence that may not be reported?

Timely and actionable data.

Lag times in reporting mean that secondary data are typically old data — two, three, even five or more years old. Changes in the economy, healthcare infrastructure and available services oftentimes make those data obsolete before you even start. Even BRFSS data – for those communities in which it is available (which often is not the case) – reflects findings that are at best two years old, and many times more than five years old.

Geographically targeted and flexible data.

Secondary data are generally available only at predefined geographic levels corresponding to geopolitical boundaries that may not reflect your community. Most often there is not an option to isolate the findings for particular segments, either. In fact, large-area analyses can often either mask or overstate problems for your community if the geography isn't precisely matched.

Only primary data gives you a chance to drill-down into indicators to understand where the disparities exist in your community. IRS Form 990 Schedule H asks if your CHNA describes the "primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups." Only by drilling down into primary data can you truly get at this information.

Ability to customize measures to your specific needs.

Secondary data are by definition data that someone else has collected, and typically for purposes different than yours. Primary data gives you a chance to design your own indicators. What information do you need to evaluate or support existing programs? What information do you need to support grant applications or rally the community around an issue?

Case File

Methodist Health System Foundation • Slidell, Louisiana

Legacy Foundation Helps Community

Recovering after Katrina Devastation

Hurricane Katrina took away people's livelihoods, homes and even their healthcare along the Gulf Coast. The East New Orleans area was especially hit hard, and seven years later is still trying to come back from the sheer devastation left behind – and the Methodist Health System Foundation (MHSF) is at the epicenter of those efforts.

Established in 1983 as the system holding company of Pendleton Memorial Methodist Hospital, MHSF also serves as a vehicle for integration of related healthcare services and as the major fundraiser for the hospital.

In 2003, Universal Health Service became the majority owner of the hospital, and MHSF created a formal mission for their Legacy Foundation. Then, in August of 2005, Hurricane Katrina hit. The two hospitals operating in New Orleans East were inundated by flood waters and damaged to the point where they were forced to close.

There were no longer any hospitals in New Orleans East, and there was no way to quickly repair the damage or rebuild. The closest emergency room and full-service hospital was – and still is – 30 minutes away.

MHSF decided to begin their own rebuilding process, and in 2008 they moved into their current home in Slidell, Louisiana.

According to MHSF President Fred Young, New Orleans East has the same basic demographic and economic diversity as New Orleans, with a population of both the very wealthy and the extremely poor. After Katrina destroyed much of the infrastructure of the area, wealth didn't influence access as finding healthcare became difficult for everyone.

East New Orleans essentially became a greenfield project: They couldn't simply repair and rebuild – they had to start from the bottom up. It took several years to even be able to track the population and determine what was needed in healthcare.

Before rebuilding, MHSF realized they first must determine the needs of their community. They knew that the needs had changed since Katrina, but they didn't

know what the most pressing issues were or where they needed to start. To answer those questions, MHSF contracted with PRC to conduct a Community Health Needs Assessment in 2011. Young says, "We felt like it was our vocation to do this. We needed to find out what people needed."

MHSF used the CHNA data – along with their core values of Courtesy, Concern, Kindness and Compassion – to determine their strategy and priorities. As expected, they found that there were some great needs within the community, primarily the lack of a hospital in the area.

"It's no surprise that the first thing we needed to address was bringing a hospital back to the area," explains Young. "This is a long-term project, obviously. The city and other entities are now involved in the project, and it is anticipated that there will be a two-year window from the time construction starts to get a hospital open."

Providing a healthy start

Another need the assessment uncovered was immunizations. After Katrina, many medical records were missing or unobtainable, and a standardized process to keep records on immunizations and other medical information became necessary.

MHSF partnered with the Greater New Orleans Immunization Network to provide free immunizations for children from birth to 18 years old. With their Mobile Immunization Unit's regular neighborhood visits, children in many locations now benefit from their services. They also maintain a registry of immunizations, which is shared with all ten area network hospitals.

Another MHSF grantee, the School Kids Immunization Project, partners with 18 area schools and has provided more than 13,000

vaccines to students. To help ensure recordkeeping, those immunizations are entered into a statewide immunization database.

Keeping kids healthy

One concern the assessment uncovered is that high-school aged adolescents weren't seeking healthcare, even when it was a necessity. To that end, the MHSF School-Based Health Center was created. By offering medical and mental healthcare services on school campuses, they could help keep students healthy, keep them in school and improve their academic capabilities.

The first clinic opened in 2006 in St. Barnard Parish's Chalmette High School and sees an average of 40 to 50 students per day during school hours. They have treated upwards of 1,200 students to date.

According to Young, these clinics deal primarily with episodic intervention, but they also handle maintenance medications such as insulin shots and monitoring for diabetes.

The clinic at Chalmette High School is staffed by a physician, a psychiatrist, an RN, three nurse practitioners, a social worker and more. There is also dental healthcare available. (See http://www.mhsfi.org/services_programs/ for more information.)

All treatment is provided at no cost to the students, and the clinics file claims for those with insurance or Medicaid while they write off treatment for the uninsured.

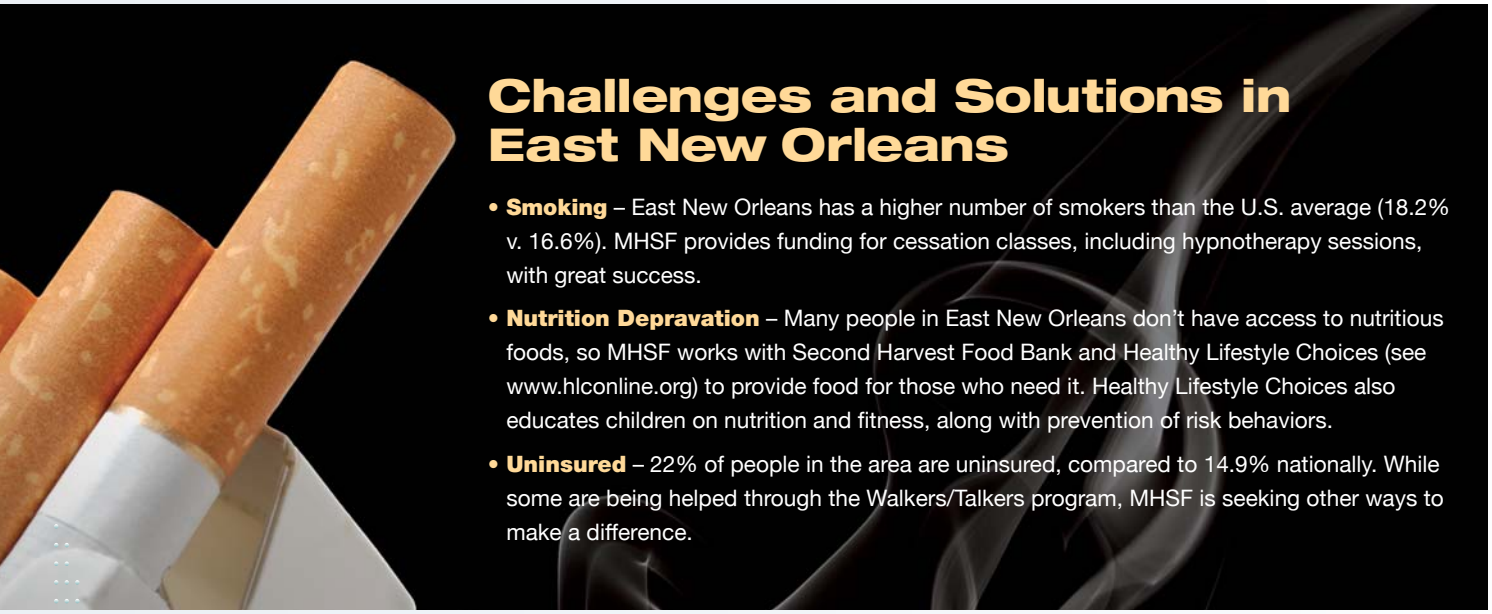
"It's really part of our mission as a Christian organization," says Young. "The high school clinic costs about $500,000 per year to operate. They receive state and private grants for about $200,000 to $225,000. The Foundation subsidizes the rest."

Healthcare expos provide free screenings

In partnership with Blue Cross and Blue Shield of Louisiana Foundation, MHSF funds health screenings through Sign Up Friday.

During Sign Up Friday, kids are bused to a central location for vision and hearing screening, along with fitness and body fat testing. They also learn about health and their bodies through physical activities and health education.

In 2012, more than 2,500 children participated in Sign Up Fridays. Of those



Challenges and Solutions in East New Orleans

- **Smoking** – East New Orleans has a higher number of smokers than the U.S. average (18.2% v. 16.6%). MHSF provides funding for cessation classes, including hypnotherapy sessions, with great success.
- **Nutrition Depravation** – Many people in East New Orleans don't have access to nutritious foods, so MHSF works with Second Harvest Food Bank and Healthy Lifestyle Choices (see www.hlconline.org) to provide food for those who need it. Healthy Lifestyle Choices also educates children on nutrition and fitness, along with prevention of risk behaviors.
- **Uninsured** – 22% of people in the area are uninsured, compared to 14.9% nationally. While some are being helped through the Walkers/Talkers program, MHSF is seeking other ways to make a difference.

The Evolution of Grants

After Hurricane Katrina, the Methodist Health System Foundation used transom granting, putting out requests for proposals and letting potential grantees apply with them.

Today, they focus on strategic granting, seeking out those organizations that best meet their objectives and priorities. The MHSF partners with like-minded, nonprofit and highly successful providers instead of searching for grantees, using the power of their CHNA data and established, proven organizations to do the most good in their community.

children, 26% were found to have a vision deficiency, 7% had hearing issues and 9% failed the fitness test.

"After the screenings, we help them with public assistance, referrals to doctors and more," says Young. "It's much more than just free health testing."

Grants fund needed services

Another MHSF grantee is Kingsley House, a nonprofit social services provider in New Orleans. "We provided the Kingsley House a grant for their Walkers/Talkers program, which sends people out into the community to assist those who need help to access services including behavioral health," explains Young.

The Walkers/Talkers volunteers knock on doors, talk to the residents and enroll those who are eligible for Medicaid and Children's Health Insurance Program. This program has been so successful that Walkers/Talkers has had times when they've spent the whole day knocking on doors to not find one person who needs their assistance.

"We've made an impact, but there are still so many people in need here," says Young. "Emotionally, we want to take care of everyone, especially after Katrina. Of course, we can't do that. We needed a mechanism to set priorities, so we can use our resources in the most effective way possible. That's what our Community Health Needs Assessment does for us.

"We'll conduct another survey in three or four years to make sure we continue to move in the right direction."

Professional Research Consultants, Inc.
11326 "P" Street
Omaha, Nebraska 68137-2316

Let PRC Help You Nail Your IRS Requirements

With PRC conducting your Community Health Needs Assessment, you will automatically meet these IRS 990 Schedule H requirements:

- ✔ Every three years conduct a CHNA that takes into account input from persons who represent broad interests of the community as well as those with special knowledge or expertise in public health
- ✔ Make the results of each assessment widely available to the public
- ✔ Prioritize the health needs of the community
- ✔ Develop an implementation strategy to address the health needs identified through the assessment

Mark the Date

IRS 990 states that non-profit hospitals must conduct a CHNA once every three years, with the first assessment completed by the end of the tax year beginning after March 23, 2012.

Beginning of Hospital's Fiscal Year:	Hospital's Initial CHNA + Public Dissemination + Implementation Strategy Adopted By:
April 1	March 31, 2013
July 1	June 30, 2013
October 1	September 30, 2013
January 1	December 31, 2013